(5) Non-covered charges combined under a separate heading;

(6) Total charges;

(7) Any partial payment made by third party payors (claims paid equal to or in excess of Medicaid payment rates by third party payors shall not be included in the log);

(8) Medicaid payment received or adjustment taken; and

(9) Date of remittance advice upon which paid claim or adjustment appeared.

(c) A year-to-date total must appear at the bottom of each log page or after each applicable group total or a summation page of all subtotals for the fiscal year activity must be included with the log; and

(d) Not to be included in the outpatient log are claims or line item outpatient charges denied by Medicaid or claims or charges paid from an established Medicaid fee schedule. This would include payments for General Relief recipients, payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a Medicaid provider type other than hospital outpatient.

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in Section V B.1. of this plan.

3. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 413.20. If an audit by or on behalf of the state or federal government has begun but is not completed at the end of the three (3)-year period, or if audit findings have not been resolved at the end of the three (3)-year period, the reports shall be retained until resolution of the audit findings.

4. The Missouri Division of Medical Services shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.

C. New, Expanded, or Terminated Services

1. A hospital, at times, may offer to the public new or expanded services for the provision of allowable inpatient or outpatient services which require Certificate of Need approval; or permanently terminate a service. Within six (6) months after such an event, the hospital must submit a budget which shall take into consideration new, expanded, or terminated services. Such budgets will be subject to desk review and audit. Upon completion of the desk review, reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and budget shall disqualify the hospital from receiving a rate increase. Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

2. Failure to submit a budget concerning permanently terminated services may result in the imposition of sanctions.

3. Rate adjustments due to new or expanded services will be determined as total allowable project cost multiplied by the ratio of total inpatient costs (less swing bed cost) to total hospital cost as submitted on most recent cost report filed with the agency as of review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

4. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

D. Audits

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

   (a) Desk review all hospital cost reports;

   (b) Determine the scope and format for on-site audits;

   (c) Perform field audits when indicated in accordance with Title XIX principles; and

   (d) Submit to the state agency the final Title XVIII cost report with respect to each such provider.

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospitals fiscal year and shall make any recoupments necessary to ensure Title XIX payments for inpatient services do not exceed Title XIX reasonable costs. With the exception of those hospitals identified by the Medicare intermediary as nominal charge providers, the lower of aggregate per-diem cost or charge requirement will be applied. The state agency review shall not result in additional payments to the hospital.

3. Inpatient cost settlements determined in accordance with paragraph V.D.2. and initially determined on or after January 1, 1990 shall be waived proportionately, based on Medicaid inpatient days, for the time period the facility qualified for increased payments in accordance with subparagraph VI.B.I.(e)(2).

E. Adjustments to Rates

The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Medicaid agency from imposing any sanctions authorized by any statute or regulation;

2. When rate reconsideration is granted in accordance with subsection V.F.; and

3. When the Medicare per-diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the Division of Medical Services.

4. Effective April 18, 1992, children's psychiatric hospitals shall be eligible for a prospective rate adjustment based on the difference between a per diem rate computed in accordance with Section III using the most recent desk reviewed cost report and the current per diem rate. A children's psychiatric hospital is defined, for the purpose of this subsection, as a facility accredited by the Joint Commission on Accreditation of Hospitals Organization (JCAHO) primarily for the care and treatment of psychiatric disorders of children which also operates, within a one (1)-mile radius, a residential treatment program for children which is also accredited by the JCAHO. The effective date for any prospective rate adjustment granted under this subsection shall be the first of the month following the Division of Medical Services' final determination on the rate request, except for requests submitted by May 18, 1992, which shall be effective April 18, 1992.

F. Rate Reconsideration

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in paragraph I.A.3. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division of Medical Services' final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the Medicaid Agency:

   (a) Substantial changes in or costs due to case mix; or

   (b) New, expanded or terminated services as detailed in subsection V.C.

(c) When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

3. The following will not be subject to review under these procedures:

(a) The use of Medicare standards and reimbursement principles;

(b) The method for determining the trend factor;

(c) The use of all-inclusive prospective reimbursement rates; and

(d) Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

4. As a condition of review the Missouri Division of Medical Services may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the State Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Agency's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty (60)-day period, the request shall be deemed denied.

G. Sanctions

Sanctions may be imposed against a provider in accordance with applicable state and federal regulations.

VI. Disproportionate Share

A. Beginning State Fiscal Year 1989, in accordance with part 2 section 6411(c)(3) of the Omnibus Budget Reconciliation Act of 1989, the State of Missouri shall be treated as having met the requirement of section 1902(a)(13)(A) of the Social Security Act (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs) for the period beginning with July 1, 1988, and ending with (and including) June 30, 1990, if the total amount of such payments for such period is not less than the total of such payments otherwise required by law for such period.

Inpatient hospital providers may qualify as either a first tier or second tier disproportionate share hospital based on the following criteria. Hospitals shall qualify as disproportionate share hospitals for a period of only one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue their disproportionate share classification.

1. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a Metropolitan Statistical Area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987, and

2. As determined from the third prior year desk reviewed cost report, the facility must have either--

   (a) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean Medicaid inpatient utilization rate for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by

the provider's total number of inpatient days (TNID). The state's mean Medicaid inpatient utilization rate will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded; or

$$MIUR = \frac{TMD}{TNID}$$

(b) A low income utilization rate in excess of twenty-five percent (25%). The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(1). Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts etc.) for patient services plus the cash subsidies, and;

(2). The total amount of the hospitals charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party or personal resources) less cash subsidies directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to charity care shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a State Plan.

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

3. As determined from the third prior year desk reviewed cost report, the facility has either:

   (a) A paid to billed day ratio which reflects less than 85% of its Missouri Medicaid inpatient days were reimbursed as a result of program benefit limitations. The paid to billed day ratio will be based on claims processed as of March 1 preceeding the qualifying state fiscal year; or

   (b) An unsponsored care ratio of at least 10%. The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenues as provided by the Missouri Hospital Association subject to verification by the Division of Medical Services.

4. Those facilities which meet the criteria estab lished in paragraph VI.A.1., 2. and 3. shall be deemed first tier disproportionate share providers. Those facilities which only meet the criteria in paragraph VI.A.1. and VI.A.2. shall be deemed second tier facilities.

B. Rates for disproportionate share hospitals shall be phased in only during state fiscal year 1989 as follows:

1. Effective July 1, 1988, only those first-tier disproportionate share hospitals which were also deemed disproportionate share on June 1, 1988 under the previous methodology implemented October 1, 1986 shall be paid a rate computed in accordance with paragraph VI.C.1.

2. Effective October 1, 1988, all first tier disproportionate share hospitals will be paid a rate computed in accordance with paragraph VI.C.1.

3. Effective January 1, 1989, all first tier disproportionate share hospitals will be paid a rate computed in accordance with paragraph VI.C.2.

4. Effective January 1, 1989, second tier disproportionate share hospitals will be paid a rate computed in accordance with paragraph VI.C.1.

C. Disproportionate Share Hospital Rate Determination

1. Data from the third prior year desk-reviewed cost report will be used to determine a rate in accordance with the following formula subject to the adjustment described in paragraph VI.C.3.

Per Diem Rate = $\frac{OC}{MPD} + \frac{CMC}{MPDC}$

(a) OC-the operating component is the hospital's total allowable cost less CMC. Only the operating component will be increased by the trend indices for the second and first prior fiscal years as described in subsection I.F. of this regulation;

(b) CMC-the capital and medical education components of the hospital's total allowable cost;

(c) MPD-the number of Medicaid inpatient billed days for service dates in the applicable cost report period multiplied by the paid-to-billed-day ratio per subparagraph VI.A.3.(a);

(d) MPDC - MPD as defined previously with a minimum utilization of sixty percent as described in paragraph V.C.4; and

(e) An additional increase of ten percent (10%) will be added to the rate if the facility--

(1) Is not operated by the State; and

(2) Has an unsponsored care ratio that exceeds sixty-five percent (65%). The ratio is determined as the sum of bad debts and charity care divided by total net revenues (TNR) as provided by the Missouri Hospital Association subject to verification by the Division of Medical Services.

2. Effective for inpatient admissions on or after January 1, 1989, the rate for first tier disproportionate share providers shall be determined as follows:

(a) First tier disproportionate hospitals shall be exempt from length of stay limits except as they apply to General Relief Recipients. Allowable days for claim payment will be the medically necessary billed days of service for which the patient was Medicaid eligible.

(b) The formula for calculating a rate in paragraph VI.C.1. will be revised to change the definition of MPD to the number of days billed.

3. All estimated disproportionate share payments for each hospital determined as the product of the applicable disproportionate share rate per subsection VI.B. times allowable days for claim payment per agency determination will be compared against the minimum payment amounts per federal regulations. The disproportionate share rate will not be subject to the Medicare rate limitation specified in paragraph 1.A.2.

(a) The federal minimum payment per-diem rate, not to exceed the Medicare rate limitation specified in paragraph I.A.2., will be the general plan per-diem per subsection 1.A. of this plan plus a minimum percentage determined as--

(1) One-half (1/2) the amount by which the provider's Medicaid inpatient utilization rate, as described in subparagraph VI.A.2.(a), exceeds the sum of the state's mean Medicaid inpatient utilization rate plus one (1) standard deviation; plus

(2) Two and one-half percent (2.5%); or

(3) If the hospital's Medicaid inpatient utilization rate does not exceed the state's mean Medicaid inpatient rate by at least one (1) standard deviation, the facility's federal disproportionate share payment adjustment percentage will be two and one-half percent (2.5%).

(b) The federal minimum payment amount for the facility will be determined as the product of the federal minimum payment per-diem rate, as established in subparagraph VI.C.(3)(a), times the allowable days for claim payment per program benefit limitations as determined by the Division of Medical Services.

(c) If the federal minimum payment amount in subparagraph VI.C.3.(b) exceeds the estimated disproportionate share payments as determined in paragraph VI.C.3. the provider's Missouri Medicaid disproportionate share per diem rate shall be adjusted to a level at which the federal minimum payment amount equals the rate multiplied by the applicable number of days.